

## ASSISTANCE REQUEST SURVEY

Arizona Public Service Company has established "Operation Outreach" as a means of educating and informing residents about nuclear power in general and the Palo Verde Nuclear Generating Station specifically. They are working closely with federal, state and county emergency management agencies to provide for your health and safety. Maricopa County Department of Emergency Management uses this form in their planning and requests that you complete this informational form whether assistance is needed or not. To get more information you can contact the Maricopa County Department of Emergency Management at 602-273-1411/AZ Relay Service 711 or 602-244-1409(TTY). *If you cannot complete this form on your own, please have a family member, caregiver or other representative complete the form and submit on your behalf. You can fill this form out on-line at [www.maricopa.gov/Emerg\\_Mgt](http://www.maricopa.gov/Emerg_Mgt) or call 602-273-1411/AZ Relay Service 711 or 602-244-1409(TTY) for assistance completing.*

### "PLEASE PRINT"

NAME(S) OF PERSONS LIVING IN HOUSEHOLD (Please include first and last names)	AGE	Assistance Needed?
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

Residential Address: House number: \_\_\_\_\_ Direction: \_\_\_\_ Street: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number(s): Residence: \_\_\_\_\_ Cell: \_\_\_\_\_

☐ Yes ☐ No 1. Would you, or any member of your family, (including children or elderly home unattended during the day), require additional assistance to leave your home on short notice? Please check ALL that apply that best describe any disability or medical condition that affects your mobility.

- ☐ Use a Walker or Cane (Necessary for Mobility)
- ☐ Use a Wheelchair (Necessary for Mobility)
- ☐ Unable to be out of Bed (Have no mobility)
- ☐ Use a Ventilator/Respirator (Needed to sustain life)
- ☐ Use Portable Oxygen Equipment (Needed to breathe)
  - ☐ Tank
  - ☐ Concentrator
- ☐ Require Electricity For Life Sustaining Equipment (Needed to operate any life sustaining devices)
- ☐ Service Animal

Please note any other assistance you would require: \_\_\_\_\_

☐ Yes ☐ No 2. Please check ALL that apply that best describe any disability or medical conditions.

- ☐ Deaf/Hard of Hearing Impairment
- ☐ Blind/Visual Impairment
- ☐ Cognitive
- ☐ Autism Spectrum Disorder

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- ☐ Seizure Disorder
- ☐ Speech Disability
- ☐ Alzheimer's/Dementia
- ☐ Psychiatric Disability
- ☐ Non-Verbal Communication
- ☐ Other: \_\_\_\_\_

☐ Yes ☐ No 3. Do you have a telephone? Telephone No.: \_\_\_\_\_

☐ Cell ☐ Text Capable ☐ Smart Phone

☐ Yes ☐ No 4. Will you need transportation during an emergency?

☐ Accessible Transportation?

☐ ☐ 5. Do you have pets? (If so, how many and what type?)

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